TAMJIDI SKIN INSTITUTE

New Patient Registration Form

PLEASE WRITE LEGIBLY

Patient's name: _____ **Title**: _____
First *Last* *Mid*

Date of Birth: ____ / ____ / ____ (age: ___) **Sex**: Male / Female **SSN#**:_____

Address: _____ (APT#: ___) _____
City *State* *Zip*

(Please check your **ONE** primary number)
□ **Home phone**: _____ □**Work phone**: _____ □**Mobile phone**: _____

Email address: _____

Appointment reminder preference (Please check ONE): □Email □Text □Call(voice message)

Emergency contact's name & relationship: _____ **Phone**: _____

Marital status: Single / Married / Divorced / Widowed **Race**: _____

Employment status: FT / PT / Retired / N/A **Employer**: _____ **Occupation**: _____

Employment address: _____

Insurance

Company name: _____

Policy #: _____

Group #: _____

Please present the hard copies of your most *up-to-date insurance card* and *government-issued photo ID* to the front desk.

Referred by/How did you hear about us: _____

_____ _____
Patient Signature **Date**

NOTICE OF PRIVACY RIGHTS
PATIENT ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information
that may be made by this practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practice, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature _____

Date _____

Relationship to patient (if signed by a personal representative of patient)

_____

I give permission for my healthcare provider to discuss my medical care and/or results with the following person(s). This is optional.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

TAMJIDI SKIN INSTITTUE

Financial Policy

1. Payment in full is due at the time of service unless prior arrangements have been made.

2. Office visit co-pays for our participating HMO/PPO insurances are due at the time of service

3. If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 45 days for the balance to be paid. If your insurance carrier does not remit payment within 45 days, the balance will be due in full from the responsible party. If your insurance company subsequently pays in excess of the balance, we will gladly hold the credit for future appointments or refund the credit balance within 30 days providing you have no other outstanding accounts with our office.

4. **REFERRALS ARE THE PATIENT'S RESPONSIBILITY**, HMO/PPO claim denials due to no referral or authorization are the patient/guarantor's responsibility. Office staff will assist you in referral/pre-authorization procedures, but final responsibility lies with the patient/guarantor to comply with their insurance's specific requirements. ***The referral must be presented to the front desk before the patient can be seen by the doctor.*** If you are present for your appointment without your referral, you will be asked to reschedule.

5. Please present your insurance card each time you visit if we participate with your plan to ensure proper filing information to submit claims. Otherwise your visit may not be covered and financial responsibility will become the patient's/guarantor's.

6. There is a $50.00 charge for all returned checks.

7. Please be on time for your appointment. If you need to reschedule your appointment, we require a minimum of 24 hours notice. If you missed a scheduled appointment without notifying our office, a $40.00 charge will be added to your account. If your appointment was cosmetic in nature, the fee will be $75.00

8. If your account must be forwarded to a collection agency and/or attorney because of non-payment, you will be responsible for all fees associated/charged by these services.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have/has coverage with _____ and assign directly to the Tamjidi Skin Institute (Pantea Tamjidi, MD,PC) all insurance benefits payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-pays, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature:_____

Printed Name:_____ Date: _____

NAME:_____ **DATE OF BIRTH:**_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Other
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Other
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Other

Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No
If yes, how often? _____

Family History: First Degree Relation: (Please circle all that apply)

Hypertension
Thyroid Disease
Diabetes

Colon Cancer
Breast Cancer
Hypercholesterolemia

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications, dosages, frequencies)

_____
_____
_____

Allergies: (Please enter all allergies)

_____

Social History: (Please circle one)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
YES
NO

Language:
English
Spanish
Other:_____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Pharmacy:

Name: _____ City: _____
Address (**BE SPECIFIC**): _____
Zipcode: _____

Name:_____ DOB:_____

PATIENT INTAKE FORM

All insurance carriers require this form to be completed for every single visit!
Please answer the following questions so we can comply with your insurance at our practice. Thank you!

1.) Did you receive the flu vaccine? YES or NO

2.) Have you ever received the pneumonia vaccine? YES or NO

3.) Do you have a history of Melanoma? YES or NO

4.) Do you smoke? YES or NO

5.) How many times in the past year have you had 5 or more alcoholic drinks in a day for men, or 4 or more alcoholic drinks in a day for women or any adult older than 65?

0 1 2 3 4 5

6.) Are you experiencing any type of generalized skin pain? YES or NO

Please circle the appropriate number associated with your skin pain level, with 0 as NO pain and 10 as extreme pain.

 **0 1 2 3 4 5 6 7 8 9 10** 

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.